

ANDREW M. CUOMO Governor RICHARD A. BALL Commissioner

## AMERICANS WITH DISABILITIES ACT COMPLAINT FORM

Please use this form to file a complaint based on disability in the provision of services, activities, programs or benefits.

Please submit this form to the ADA Coordinator, Mark Lansing at The New York State Department of Agriculture and Markets, 10B Airline Drive, Albany, NY, 12235, or at mark.lansing@agriculture.ny.gov.

## **COMPLAINANT INFORMATION**

Name	:	Home Phone:
Home Address:		Email:
1.	Your claim is made against:	
	State Agency:	
	Name:	
	Title:	
	Address:	
	Phone:	
2.	Location(s) and date(s) of the circum	mstances giving rise to your complaint:
	Are the circumstances of your comp	plaint continuing?

3.	<ol> <li>Please describe the alleged denial of services, activities, and your reason(s) for concluding that the conduct was d include the name(s) of witnesses, if any, and attach supporti</li> </ol>	liscriminatory. Please
4.	<ul> <li>4. A. Have you filed a claim regarding this complaint with a federal government agency?</li> <li>□ YES □ NO</li> </ul>	eral, state or local
	B. Have you hired an attorney with respect to the allegations $\hfill \square$ YES $\hfill \square$ NO	in the complaint?
	C. Have you instituted a legal suit or court action regarding to YES $\;\;\square$ NO	his complaint?
5.	5. This complaint form was completed by:  □ ADA Coordinator □ Complainant	
Signa	nature: DATE	E: